Community mental health care in the Asia-Pacific region: using current best-practice models to inform future policy

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The vast experiences from the community mental health care models in the Asia-Pacific region can serve as valuable lessons and inspiration for future development. For positive change to occur, it is clear that innovative, culturally sensitive and economically sustainable pathways for community treatment models need to be explored and developed. The Asia-Pacific Community Mental Health Development (APCMHD) project has been established to explore diverse leading models or approaches to community mental health service delivery in the Asia-Pacific region. It aims to illustrate and promote best practice in mental health care in the community through use of information exchange, current evidence and practical experience in the region. The project is based on the work of an emerging network of mental health leaders from 14 countries or regions in the Asia-Pacific, working to build culturally appropriate mental health policy frameworks and workforce in the implementation of community mental health services. Some of the key guiding principles of developing community mental health care in the region are highlighted. Such collaborative exchange based on local practices will help enhance regional solutions to challenges in building capacity and structures for community-based mental health systems in the future.

Key words: Community mental health, local models, principles of care, culture and service delivery

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The Asia-Pacific region has close to half of the estimated 450 million people affected by mental illness globally (1).

Based on international mental health care benchmarks, many Western health systems have established contemporary health policy and guidelines which include the provision of mental health care in the community. However, the delivery of quality and appropriate community mental health care remains an ongoing challenge for countries of both high and low socio-economic level. Difficulties and obstacles in implementation of comprehensive community service models include inadequate funding, availability of trained mental health workforce, integration with primary care services and community agencies, and collaboration between public and private health systems (2,3). As community mental health service system depends on sufficient workforce for service delivery, the critical shortage of adequately trained mental health staff continues to impede the progress of mental health reform.

In response to such global trends, many countries in the Asia-Pacific region have begun to establish mental health policy and guidelines to move from institutional care to community mental health services. While these reforms are supported by recommendations from the World Health Organization (WHO) governing bodies, such as the Western Pacific Regional Mental Health Strategy (4), social, economic and cultural factors in Asia-Pacific countries often do not allow ready translation of Western community mental health models of care. Governments and service providers commonly face challenges in the development and implementation of locally appropriate community mental health care and services. Additionally, it would be unrealistic or undesirable to produce rigid recommendations for a singular community mental health care model, due to the diversity across the Asia-Pacific region. Hence, for constructive change to occur in the region, innovative, culturally appropriate and economically sustainable pathways for community treatment models need to be explored, developed and shared. Community mental health service reform appears to be gaining momentum in this region, despite the obstacles. Valuable lessons and inspiration for further development can be gained from both the successes and difficulties in reforming mental health systems and practices in the region.

An emerging network of representatives from governments, peak bodies and key organizations is emerging in the Asia-Pacific region to build supportive relationships in order to facilitate the implementation of locally appropriate policy frameworks for community mental health service reform. The network is supported by the Asia-Pacific Community Mental Health Development (APCMHD) project, which involves 14 countries/regions in the Asia-Pacific region. Initiated in collaboration with the WHO Western Pacific Regional Office, the APCMHD project is led by Asia-Australia Mental Health, a consortium of the University of Melbourne Department of Psychiatry and Asialink, and St. Vincent's

Health, which is a part of the WHO Collaborating Centre for Mental Health (Melbourne). The project, which brought many key mental health organizations to work collaboratively, is consistent with the WHO Global Action Programme for Mental Health (5).

The project aims are to promote best practice in community mental health care through exchange of knowledge and practical experience in the Asia-Pacific region. The key outcome is the documentation of the current status, strengths and needs of community mental health services in the region, in the hope to translate current understanding into practical changes in the future.

STAGES OF THE PROJECT

The project involved a three stage process of development over three years. Best practices in community mental health care in the Asia-Pacific region were identified and examined through collection of national data, existing evidence, information exchange, and practical experience. A total of 14 countries/regions participated in the project, including (in alphabetical order) Australia, Cambodia, China, Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Mongolia, Singapore, Taiwan, Thailand, and Vietnam. A network of representatives from ministries of health and key mental health organizations in the region worked to produce guiding principles for the development of culturally appropriate practices of community mental health care. Significant progress was made as a result of the good will and enthusiasm of the participants, who valued sharing real-life practices and solutions. Asia-Australia Mental Health, WHO and the project partners provided technical support and continuously reviewed the progress of the participating countries in this project.

Stage 1: Developing the framework for data collection

Preparatory work meetings with key country representatives were held in 2005-2006 at key conferences in Asia to scope the project, plan directions and agree on working methodology to ensure consistency of documentation of existing community mental health resources, policy and practice across the countries and regions.

Stage 2: Producing resources for best practice

A draft report template was developed by the country representatives, based on the project goals, to assist each country or region to document mental health policies, strategies, and the diverse local models or approaches to community mental health service delivery. A consensus meeting was convened at the WPA International Congress in Melbourne in November 2007 to clarify the methodology and report the information collected from participating countries.

Stage 3: Publication, dissemination and implementation

A regional report has been published (6), based on experiences and learning gained, to provide a resource to inform future policy development and implementation of community based services. Publication of the report and dissemination of information to the regional countries will be followed by implementation of planned outcomes. Full reports for each country/region are available on www.aamh.edu.au.

KEY PRINCIPLES FOR BUILDING COMMUNITY MENTAL HEALTH CARE IN THE ASIA-PACIFIC REGION

Cost-effective models of community mental health care need to be scaled up throughout the region. A number of focal approaches are deemed to be particularly relevant for the local environment, culture, and mental health system in the Asia-Pacific countries. The following key guiding principles are distilled from the analyses of different regional exemplars of best practice, some of which are briefly outlined below together with the corresponding principles.

Emphasis on community-based care in the hospital system

The concept of community mental health service takes different meanings in different cultures and varies throughout the region. Community-based care can be developed within a mental health hospital system. Many hospitals have developed community outreach teams to provide specialist mental health services in local settings, and to train primary health workers and community agencies. While adequate beds for acute care must still be provided, alternative community mental health services are needed to facilitate early discharge, optimize treatment and rehabilitation outside the hospital, and prevent relapses of illness or re-hospitalisation. Community-based care must be incorporated within a balanced mix of service components, ranging from psychiatric hospital care to general hospital and primary care.

The Hospital Bahagia Ulu Kinta in Perak, Malaysia, is a large psychiatric hospital which has developed home care services offering individualized rehabilitation in the community. The large tertiary hospital is the "hub" which administers and resources the "spokes", which are the community mental health centres. Resources are gradually moving from the hospital's bed-based services to the community-based services. Relapse and re-admission rates have been reduced from 25% to 0.5%.

The Kyonggi Provincial Mental Health Program in Korea established 14 community mental centers across the Kyonggi province in 1998, providing essential services such as day care services, case management, family support,

community education, and linkage to various community resources. Owing to its successful implementation, the Ministry Division of Mental Health adopted Kyonggi's model project in starting a national mental health project in 1999.

Equitable access to mental health care

Access to basic mental health care usually means access to practitioners with mental health training, basic medications and family support. To support basic mental health care, access to specialist services, including acute care, and to rehabilitation and vocational programs is also needed. Access may be restricted for many reasons, including geographical barriers, a shortage of trained staff and medication, social stigma, a lack of financial support, and poor patient advocacy. The transition from institution-based care to community-based care has resulted in innovative approaches to address gaps in care across the region.

The National Mental Health Service Model Reform Program or "686 Program" in China was developed by the National Centre for Mental Health to increase access to mental health care through the development of 60 demonstration areas in 30 provinces. Free clinical care and medications have been provided to thousands of disadvantaged patients. Each site covers a population of about 400,000, with a total coverage of 42.9 million. Over 600 training sessions have been conducted for psychiatrists, community doctors, allied health workers, policemen, community workers, and patients' families, resulting in more than 50,000 people being trained. Globally, this has been one of the largest mental health reforms ever seen.

The Community Mental Health Nursing (CMHN) project in Indonesia increased access to mental health care in rural areas through the use of a mobile outreach service made up of nursing staff, community health workers and medical doctors with mental health training. The CMHN provided a range of services in terms of education, support and treatment targeting patients, their families and the greater community. Through education given by this project, the community can also support mental health care and vocational rehabilitation.

Support in the transition of care from institution to community

The process of shifting from institution-based care to the community is particularly difficult for people with chronic and severe mental illnesses who have spent many years in institutions. This may be due to a paucity of resources, both personal and external, that may result from their disability and institutionalization. However, the values of autonomy, self efficacy, personal strengths and good quality of life are no less important in these patients. Patients leaving institution-based care require not only strong psychiatric support, but also practical support, such as housing assistance and vocational and life skills training, to ensure good mental health outcomes.

The Extended-Care Patients Intensive Treatment, Early Diversion and Rehabilitation Stepping Stone (EXITERS) project in Hong Kong achieves supported transition of care of long-stay patients using a 3-phase system including flexible matching of resources, active community supports and follow-up structures utilising multidisciplinary staff. Intensive rehabilitation and case-management is provided to improve social and vocational functioning.

The Flight From The Nest Group (Sudachi-kai) in Japan is a social welfare corporation with an active role in both mental health staff and peer-led discharge promotion. Further, it places a strong emphasis on vocational training and providing housing support to ensure successful discharge from hospital-based care. This community based discharge programme run by a non-governmental organization (NGO) in Japan has discharged over 126 people since the program begun.

The Ger Project in Mongolia, fostered by the WHO and SOROS Foundation, utilizes traditional portable round houses and tents called "gers" to deliver education and training in life and social skills to people with mental illness in the community. The Ger Project also provides psycho-education, counselling, family support and continuing psychiatric treatment.

Consumer and carer roles

Empowering users and carers, and the inclusion of their agenda, are critical to the planning and development of community mental health care. Many of the projects reviewed place a strong emphasis on patient autonomy. Patients' involvement in decision making regarding their care is not only in accordance with their human rights, but may also contribute to better compliance and may therefore result in better health outcomes. This is just as pertinent for people with mental illness as for those with other forms of illness. The role of a patient as consumer is powerful as it can be used to guide the future of care for people with mental illness through sharing of experience and advocacy. The role of consumer also extends beyond mental health care alone, and can be used to further validate the role of people with mental illness in the greater community.

The House of Bethel in Japan is a complex of services, self-help groups, and private firms that was established by a group of consumers. It places a strong emphasis on con-

sumer-focussed meetings, during which consumers discuss issues that they have faced, use problem-solving techniques to resolve these issues, and record their progress for the future benefit of other consumers.

Community networks and partnerships

The formation of community networks and partnerships increases the resources available to people with mental illness who are living in the community. Community partners such as community agencies, NGOs and volunteers bring valuable experience and resources that allow the development of projects which are appropriate to the patient group and their local community. They are also key partners in developing community linkages with local agencies and stakeholders.

The Mental Health Care model in Cambodia highlights the importance of effective patient advocacy by strengthening community links, and the role of families, NGOs and community agencies in mental health care. By putting emphasis on integrating mental health issues into all levels of medical training, the mental health knowledge and skills base of general health workers can be increased.

The Community-based Mental Health (CSSKTT) Project in Vietnam, by the establishment of an integrated mental health network between the provinces, initiated the development of mental health services in the community. The priority is to increase public awareness of mental illness, early detection, and access to treatment centres, therefore benefiting patients and families from underprivileged backgrounds and remote areas. This project received support from the provinces, districts, and villages.

Integration into existing health care resources

In all countries, community mental health services should be integrated with primary care and the general health system, to ensure a seamless and more cost-effective system of care, and ready access to treatment and care for those with mental illnesses. Integration will maximize holistic care of mentally ill patients who frequently have medical as well as psychological problems. In the context of limited resources in many countries, there is a need to maximize available resources and adapt to the socio-economic reality in developing appropriate community mental health services. Integration may be achieved by locating mental health workers in primary care settings or by training the primary care and community workers in basic mental health care and ensuring they receive continuing support from mental health specialists.

The District Mental Health Programme (DMHP) Model in India, launched under the National Mental Health Program, aimed to create a decentralized mental health service through the integration of mental health into the primary health care system. This is supported by the extensive network of trained health staff in the general health care system. In doing so, the DMHP also aims to raise community awareness and subsequently improve early detection, provide treatment and reduce stigma of mental illness.

The "Taipei Model", developed by the Taipei City Psychiatric Center (TCPC) in Taiwan, aims to build up a network between the hospital and the public health sector, and to facilitate follow-up visits by public health workers from 12 district health institutes to patients with severe mental illness discharged from the Center. Public health nurses are involved in the assessment, planning, implementation, and evaluation of the community psychiatric services.

Community awareness and promoting the value of mental health

The process of shifting the locus of care from institutions to the community runs parallel with stigma reduction and mental health promotion, as the very presence of mentally ill people in the community raises community awareness of mental health and illness. However, stigma is still present in many communities and acts as a barrier to accessing services. Promoting the value of mental health can be a positive and pro-active way to promote acceptance of mental illness care services, raising the community's awareness and understanding of mental health issues.

The DMHP in India employed a variety of techniques to improve mental health awareness, including the production and distribution of information booklets to youth clubs, volunteer organisations, teachers and government staff, screening of films on mental health in villages, and the creation of cinema slides to bring awareness of mental health issues to a broad audience.

The Community Based Mental Health Program (CMHP) in Thailand increases mental health awareness through the involvement of communities and their leaders in mental health promotion and prevention of mental illness in their own populations.

The primary objective of the Mental Health Promotion Project in Mongolia was to create an environment of mental health promotion, through an integrated strategy involving schools, families, NGOs and community agencies, to increase mental health awareness in the population. The use of this strategy aimed to increase community participation in mental health promotion activities, to improve the knowledge and attitude of policy makers regarding mental health, and to build inter-sectoral collabora-

tions in mental health awareness and the prevention of mental illness.

Crisis intervention

A key component of community mental health care is the provision of adequate and timely crisis intervention services to respond to people with acute psychiatric conditions or psychiatric emergencies. The crisis service should be part of a strong community mental health infrastructure which can provide ongoing care and support to reduce the incidence of psychiatric emergencies. Early intervention in acute episodes of psychiatric illness may decrease the need for hospital admission or prevent the development of chronic psychiatric disorders.

The Seoul Metropolitan Mental Health Centre (SMMHC) in Korea delivers comprehensive care to people with mental illness in the metropolitan community, using four distinct teams specializing in coordination of mental health centres, crisis intervention, providing care to homeless people with mental illness, and mental health promotion. The crisis management system also coordinates related agencies to prevent suicide and build social safety networks.

The Crisis Mental Health Intervention (CMHI) in Thailand, rapidly developed in response to the 2004 Tsunami, utilized models of community care and links with community networks and other organizations to deliver care in three phases to a large population, many of whom were displaced. Through the use of mobile mental health teams, and with the participation of primary care workers, village health volunteers and community leaders such as teachers and monks, all villages received timely and appropriate mental health care.

Early intervention

Early intervention aims to prevent chronic illness course and disability as a result of mental disorders. This can result in improved mental health outcomes, including reductions in the incidence of illness relapses, long-term complications and the need for inpatient care. Early intervention is especially critical for young people. Social withdrawal and disengagement from schooling often occur early in the illness and can have a significant impact on the young person's quality of life.

The Early Psychosis Intervention Programme (EPIP) in Singapore aims to increase early detection of mental health problems, including psychosis, through improved mental health literacy in schools. The EPIP also promotes early intervention through the training of primary care physicians in screening and the ongoing management of young people with mental illness.

The Early Assessment Service for Young People (EASY) in Hong Kong promotes early intervention by raising awareness through an extensive information campaign, assists early detection through the use of an open referral system, and provides optimal care through the use of pharmacological and psychosocial management delivered using a case management structure.

Adopting a patient-centred approach

Patients' needs are complex and vary from person to person, from group to group, and over time. A comprehensive and flexible mental health service that includes in-patient, community outreach, rehabilitation and home-based care is needed to cater for both acute episodes and long-term care for people with mental illness. Integration of various types of service provision is required to ensure continuity of care, so that patients can move between inpatient, community and home as their needs change. In meeting the variety of individual needs, services also need to be culturally sensitive and recovery oriented.

The Prevention and Recovery Care (PARC) services based in Victoria, Australia provide early intervention in the relapse process and post-acute support, and interventions to promote comprehensive care, self-management, relapse prevention and rehabilitation. Such services have both clinical and rehabilitation components, to close the gap between inpatient care and the community support system provided through the psychiatric disability rehabilitation and support sector. They reduce inpatient admissions by assisting those with acute mental illness (step up), and providing an early discharge alternative from inpatient units (step down).

A multi-disciplinary team approach, where clinicians of various mental health disciplines work collaboratively in the care of patients, is likely to provide higher quality, integrated care in the community. The team approach enables a more comprehensive care as it draws on the training and experience of all the staff involved. A multidisciplinary approach to care also promotes coordination, with all members of the treating team participating in planning comprehensive delivery of care. Community-based programs would also work closely with primary health care practitioners, NGOs and community resources, in achieving good mental health care outcomes.

The Community Psycho-Geriatric Programme (CPGP) in Singapore is a home-based clinical service that uses a multidisciplinary team approach to increase patients' access to services and the early detection of mental illness.

The CPGP places a strong emphasis on building community networks by actively engaging NGOs and community agencies. The programme provides training and support to these agencies in areas such as screening and early diagnosis of mental illness, and the ongoing management of older people with mental illness in the community.

To ensure that each patient is able to access the services they need and when they need them, it is essential to provide mental health professionals with skills to better manage and co-ordinate their activities. A co-ordinated patient-centred service is referred to as case management, which includes assessment, planning, implementation, coordination and monitoring aspects. Case management needs to be practiced differently depending on cultural contexts, resources and system preparedness. However, there are some principles that remain constant, and can be implemented generically (for example, individual service plans).

The National Mental Health Service Model Reform Program or "686 Program" in China has among its priorities to build workforce capacity to deliver a comprehensive mental health system, by up-skilling the mental health staff to enhance the practice of community care and case management. A tripartite training program is currently being conducted between mainland China, Hong Kong and Australia. Over 500 trainers have been trained in basic case management to deliver coordinated mental health care in 60 sites.

DISCUSSION

The Asia-Pacific region is characterized by great diversity of people, culture, ethnicities, languages, socioeconomic development, climate, geographical features and government systems. There is also wide variation among the countries in terms of population, gross national product, social infrastructures, health systems, education resources, and employment rates. In recent times, rapid socioeconomic development, population growth, propensity for natural disasters, threat of viral epidemics, shifts in social and family structures occurring in many countries in the region have resulted in significant challenges and impact on their health systems.

Throughout the region, the proportion of health budget expenditure on mental health is generally low compared to Western countries. While mental health funding is provided mostly by government budgets or insurance systems, in a number of countries the private sector, NGOs and international aid contribute significantly to the mental health resources. A common issue across nearly all countries has been the relative lack of resources in mental health, in terms of funding, workforce, facilities, availability of psychotropic drugs and research provisions. While most countries have mental health policies and plans, and many have mental health legislation, the standards and quality of mental health service provision vary widely between and within countries. Stigma associated with psychiatric conditions and lack of community acceptance of mental illness remain a major barrier throughout the region.

Community psychosocial rehabilitation facilities provide better and earlier care for people with mental disorders, help preserve the human rights of mental illness sufferers, and limit the stigma of mental health treatment. Globally, however, community care facilities exist only in 68.1% of countries, and in several regions, including South-East Asia, such facilities are only available in about half the countries (7). Where present in Asian countries, community mental health services are not equally available and are often restricted to a few well-resourced areas within urban centres in the country. Therefore, it is necessary to develop innovative approaches to scale up and expand community mental health resources, services and facilities (8), while not negating the need to improve the standards of existing psychiatric services in psychiatric hospitals and general hospitals.

Most recently, there is evidence of new ways of thinking about community mental health in our region. Significant efforts have been made to develop locally appropriate community-based mental health services in line with the recommendations in the World Health Report (9) and WHO Policy and Service standards (5). However, the different socioeconomic and cultural factors of mental health systems in Asia-Pacific countries often do not necessarily lend direct application of a standard or Western-based approach to community mental health models of care. Locally and culturally appropriate models of care are needed to implement sustainable mental health services that can be embedded in local community and health infrastructures.

The APCMHD project has been set up to explore diverse local models or approaches to community mental health service delivery in the region. The project has found that, although there is wide diversity in the models of community mental health care across and within Asia-Pacific countries and regions, consensus derived from these experiences is useful. The exchange of information about regional practices and solutions to challenges is useful in creating locally appropriate community mental health services and care models that could be implemented within each country. Many examples of best practice models of community-based services or care can be found across the Asia-Pacific. The examples present local modifications of community mental health models, highlighting successes and gaps, as well as some of the strategies used to overcome challenges encountered.

The APCMHD project provides impressive evidence that throughout the Asia-Pacific region there is increasing emphasis on system-wide reform in community mental health care rather than a series of localized and uncoordinated initiatives. Legislation, government policy and service standards are being established to support such mental health reform. Increasing resources are being directed to the provision of community-based services, including the expansion of mental health workforce training (medical practitioners, nursing and allied

health workers) in community-based services, as well as training and support of primary health care and community workers in basic mental health care. There is increasing recognition of the human rights of mentally ill people throughout the region, while steps are being taken to increase consumer and carer involvement. Emphasis is also given to strengthening inter-sectoral links such as social welfare, housing, employment and education. There is a strong underlying enthusiastic commitment from each country to move towards best practice community mental health care with the development of innovative, locally relevant programmes to transcend the acknowledged inherent obstacles within each country.

As local successful models are analysed and better understood in terms of future practical improvements in service delivery, there are positive implications and potential for constructive development for the rest of the region. However, the process has in fact only just begun, and much more needs to be done. There is considerable consensus in the region on the guiding principles and ingredients for successful implementation of community mental health care and also what is necessary and essential to meet future challenges.

APPENDIX

The Editorial Group of the Asia-Pacific Community Mental Health Development project includes: H.M. Aminullah, R. Calder, M.L. Somchai Chakrabhand, S. Chhit, J. Fraser, M. Goding, Se-Fong Hung, Tae-Yeon Hwang, Jin Liu, Than Thai Phong, R.N. Salhan, S. Singh, T. Takeshima, G. Tsetsegdary, Kim Eng Wong, E. Chia-Husan Wu.

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